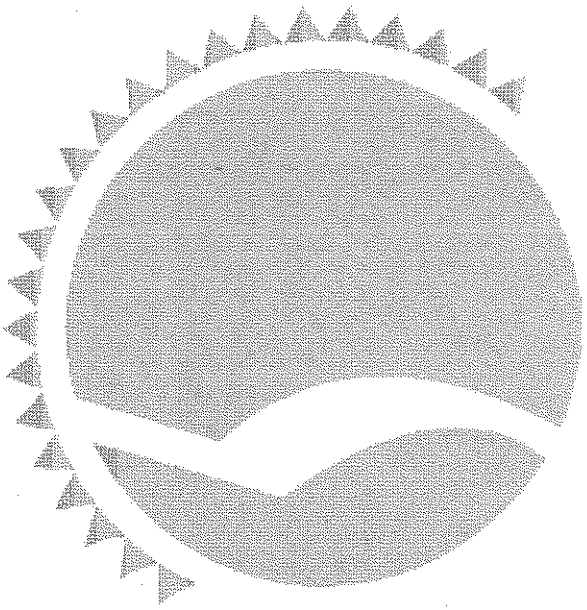
ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

April 11, 2006



CONDENSED TRANSCRIPT AND CONCORDANCE
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IN THE COURT OF COMMON PLEAS
CIVIL DIVISION
CUYAHOGA COUNTY, OHIO
CAUSE NO. 2005-CV564503

LYNN KEATING, ET AL)
)
VS.)
)
MICHAEL MAKII, M.D.)

****
VIDEO CONFERENCE ORAL DEPOSITION OF
PHILIPPE E. ZIMMERN, M.D.
APRIL 11, 2006
****

Reported By: Dawn M. Green
Job #57036

I N D E X

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EXHIBIT INDEX

VIDEO CONFERENCE ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D., produced as a witness at the instance of the PLAINTIFFS, and duly sworn, was taken in the above-styled and numbered cause on APRIL 11, 2006, from 7:00 p.m. to 8:30 p.m., before Dawn M. Green, CSR in and for the State of Texas, reported by machine shorthand, at the University of Texas Southwestern Medical Center Department of Urology, 5323 Harry Hines Boulevard, Dallas, Texas, pursuant to the Ohio Rules of Civil Procedure and the provisions stated on the record or attached hereto.

A P P E A R A N C E S

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PRELIMINARY PROCEEDINGS

PHILIPPE E. ZIMMERN, M.D.,
having been first duly sworn, testified as follows:

EXAMINATION

QUESTIONS BY MS. DONNA TAYLOR-KOLIS:

Q. Doctor, good evening.

A. Good evening.

Q. By way of introduction, my name is Donna Kolis; and I have been retained to represent Lynn and her husband, Kevin Keating in the current action which is pending against Dr. Makii. It's my understanding that you will be serving as the expert witness for Dr. Makii, and my purpose this evening is to find out what opinions you hold -- since I have a letter that's not too specific -- but be that as it may, Doctor, for the record, state your name and your professional address.

A. My name is Philippe, P-H-I-L-I-P-P-E, Zimmern, Z-I-M-M-E-R-N. And I'm a professor of urology UT Southwestern Medical Center in Dallas.

Q. Doctor, have you ever served as a medical expert before this occasion?

A. Yes, I have.

Page 5

Q. All right. And on those occasions were you required to give a deposition or testify at trial?
A. Deposition.
Q. Okay. I'm just going to briefly review deposition rules so that we have a foundational place to start from. Obviously you're doing extremely well; and you know that you have to answer my questions verbally, correct?
A. Correct.
Q. This is a pretty good video conferencing connection. I am not sensing a great delay in terms of actual voice, but we should try to be very careful to let each other finish completely our thoughts in case there's a short few seconds delay. All right?
A. All right.
Q. Okay. Can I safely assume, Doctor, since it is now 8:00 p.m. in the evening, that you do not have any professional responsibilities this evening for which we would need to interrupt the deposition?
A. I just turned my pager off. So the answer is, yes, I do not.
Q. Okay. Fair enough.

Page 6

Doctor, what are you charging me for your professional time to give this deposition?
A. Great question, and I can't answer it because I don't know the University fees. But they can be provided to you, and maybe Mrs. O'Brien knows because I really don't know. It's not something that matters to me. It goes to the University.
Q. Okay. Fair enough.
I'm certain that Ms. O'Brien will make sure that I receive an appropriate bill for this evening.
MS. O'BRIEN: I will.
Q. (BY MS. TAYLOR-KOLIS) Okay. Doctor, you have authored one report and one report only, I'm assuming; and it's dated March 27th, 2006; is that correct?
A. It is correct.
Q. All right. When were you retained in this matter?
A. I want to say a couple of weeks before that, but maybe Mrs. O'Brien knows the exact date. I have to admit I don't memorize these things well, but couple of weeks probably would

Page 7

be reasonable.
Q. All right. Do you know Dr. Makii?
A. Do not.
Q. Do you know my expert, Dr. Lee Hamontree?
A. I have heard him speak once, but that's pretty much it.
Q. All right. Do you have an opinion relative to Dr. Hamontree's reputation as a physician one way or another?
A. I do not have an opinion.
Q. Doctor, I see that sitting before you is what is probably your file. Did you bring your complete file?
A. I brought the -- all the documents that were sent to me to review and I have two pages of notes, factual notes of the date when things took place and that's it.
Q. Okay. Could you inventory for me -- that's a phrase we like to use -- what is contained in the stack of documents that you were provided?
A. Yes. On the left side here I have the office records of Lynn Keating. That's from Michael Makii, M.D. Then I have the outpatient records, Volume 1 of 3, Volume 2 of 3, Volume 3

Page 8

of 3. And then I have the deposition of Keating and Makii. One is dated December 2, 2005. The other one is dated November 4, 2005.
And as I said, I have my two-page note, one page, two pages of basically going over the chart. And I reviewed these documents just from my own -- to allow me to remember the facts in the order that things happened.
Q. Okay. And do you have also with you your correspondence file where you would have received letters from either Ms. O'Brien or Mr. Jones?
A. I do not.
Q. Okay. Fair enough.
Doctor, strange place to start the deposition, I guess. Well, wait. I'm going to think about this. The notes that you have in front of you, the two pages of notes, were those notes that you recently had written; or were those the notes that you took as you initially reviewed this case?
A. Those are the notes I initially took as I reviewed the case.
Q. Will it be possible for you to have those

Page 9

notes copied and give to the court reporter this evening?
A. I have no problem. We can ask the gentleman that set the room if he can do that, but it will be fine. It's basically --
MS. O'BRIEN: If not, Donna, we'll just give her the originals; and she can copy them, addend them to the transcript; and then he can get the originals back. But one way or another we'll get them to you.
(Deposition Exhibit No. 1 marked.)
Q. (BY MS. TAYLOR-KOLIS) Okay. Dr. Zimmern, have you, yourself, ever been a defendant in a medical negligence case?
A. I have long ago when I was a UCLA resident in training. I was named in a lawsuit and which went to full trial. So it was not directed to me directly, but I had -- as a resident I was involved in that case at UCLA. So it was not as far as anything recent, and second, nothing since I've been here at the University last ten years.
Q. All right. Relative to the lawsuit which was filed while you were at UCLA, you indicate that you were a resident. I know that was some

Page 10

time ago. Do you have a recollection of the nature of the allegations of that lawsuit?
A. Yes. I remember the case which had to do with an emergency surgery for a ruptured colon during which a ureteric injury took place. And my faculty was involved in fixing the ureteric injury and putting a stent, which then migrated. And that was one of the -- it was not the main issue. It was just a side issue. But everybody that took care of that patient was named, basically.
Q. All right. Have you ever previously worked for Ms. O'Brien, Mr. Jones, or any member of their law firm?
A. I have not.
Q. Okay. Have you, Doctor, rendered testimony in the state of Ohio by way of deposition as an expert witness?
A. Not that I recall.
Q. Focusing ever so briefly on your experience as an expert, with what frequency do you review medical-legal matters?
A. Infrequently.
Q. Well, infrequent could be once every ten years or once a year. Can you give me some

Page 11

idea of what that means?
A. Probably a couple of times a year. It varies very much on my availability of being a full-time faculty here, having residents to train, fellows to train, travel abroad. It's not a frequent thing for me to do.
Q. All right. And what kind of people -- really bad question to ask you. You don't know what kind of people they are. Are you reviewing cases on behalf of defendant doctors?
A. It can be either way, whomever contacts me.
Q. Do you have a breakdown in your mind as to what percentage of the deposition testimony that you've given has been for the doctors versus a patient?
A. No, I do not. I -- I frequently receive requests for deposition which I cannot because of the time line, you know, honor. And so I would ask someone else to help out. Or if it's just an advise through the University from my lawyers, I may review, you know, a -- a situation like that to give an expert opinion. But, no, usually I don't do much of that.

Page 12

Q. When is the last time that you can recall that you gave deposition testimony on behalf of a patient?
A. I want to say a couple of years now.
Q. And what were the medical issues involved in that case, to the best of your recollection?
A. It had to do with a woman who underwent a prolapse repair, which is a pelvic hernia. And she had some pain afterwards, and then she was -- whether this was caused by the surgery or was a pre-existing problem.
Q. And did you conclude in that matter it was caused by the surgery?
A. I, frankly, don't recall at this point what the conclusions were. I just remember, you know, kind of the overall issue about the case. But I can't remember the outcome, no.
Q. Okay. Doctor, you, of course, are board certified in urology, correct?
A. Yes, ma'am.
Q. Okay. And you recently recer- -- well, nine years ago you recertified. So you're current in your board certifications, correct?
A. And I'm going to be up for recertification again, yes.

Page 13

Q. I would think so. Okay.
A. It's every ten years.
Q. Right. What percentage of your time do you spend in the clinical practice of urology?
A. Probably -- it depends what you ask. If you ask my wife, she will say 200 percent. If you ask my chairman, he will probably say 80 percent because I have research and teaching obligations. But I see patients on Monday and Thursday every week. I operate on Tuesday, Wednesday every week. And Friday is varied between surgery and seeing patients.
Q. Okay. Doctor, I don't really have the time or the inclination to go through your CV in great detail; but I just want to ask you a couple of questions about it.
A. Sure.
Q. If I'm reading this correctly, your current academic post is director of the Bladder and Incontinence Treatment Center.
A. This is correct.
Q. Am I reading --
A. Yes.
Q. Okay. And what is your primary focus at your Bladder and Incontinence Treatment Center?

Page 14

A. Women who have incontinence problem, prolapse problem, anything that has to do with urological care of women, as well as voiding dysfunction, as well as neurogenic bladders which we see lot with patients who have multiple sclerosis, spinal cord injury, Parkinson's Disease. So it's probably 60 percent women's care and 40 percent men's care.
Q. Okay. I also noted, Doctor, from looking at your CV that you are on the Editorial Board of the Journal of Medicine and Pelvic Surgery; is that right?
A. I was until a few months ago where they rotated the -- the editorial board, which I think is a brilliant idea and -- because I'm busy enough and asked to be on other boards. So it was perfectly fine with me.
Q. As a participant in the editorial board for that journal, would you be one of the people who peer reviewed submissions to be published in the Journal?
A. Correct. I review submissions for that journal as well as The Journal of Urology, Urology, British Journal of Urology, European Urology, NeuroUrology & Urodynamics, BJU, the

Page 15

British Journal of -- those are the most frequent ones I'm asking to review. I do on average five to ten articles review per month.
Q. Okay. To the best of your recollection -- and I won't hold you to it, but as closely as you can think of it, Doctor, in the last five years in the Journal of Medicine and Pelvic Surgery, were there any articles published relative to the appropriate surgical techniques and/or management of vesico-vaginal fistula?
A. That's a great question. I just can't answer that without checking back.
Q. Okay.
A. Do you have this information?
Q. Believe it or not, I don't. I was asking you to see if you knew --
A. It's a topic that is of interest to all of us, but there are not that many publications on it.
Q. Okay.
A. I can tell you other journals I have published on it, but that particular one I don't know if they have the review or if they have a case report. I'm certainly happy to

Page 16

look into that if that can help you.
Q. Okay. Going further into your curriculum vitae, under miscellaneous on Page 9 I noted with great interest that you have something called the Vesico-vaginal and Ureterovaginal Fistula Repairs. It's a UAU, [sic,] Compact Disk Program produced in 1990, correct?
A. Correct.
Q. Where would one obtain such a compact disk?
A. Probably have -- all this belongs to the AUA Office of Education. So that would be there. It's been, what, 16 years now.
Q. Yep.
A. I don't even have it anywhere in my office I can think of.
Q. If I could -- if I could inquire, the AUA has its Office of Education where?
A. I believe it's in Baltimore, Maryland. I can provide you with the address.
Q. I can probably find it on the Internet. I'm assuming -- I hope I'm not too tired to assume wrongly, but AUA stands for the American Urological Association?
A. Association, correct.

Page 17

Q. Okay.
A. I just don't know how -- how far back they keep those records because those are courses. But it's their intellectual property once we lecture this many.
Q. Well, it never hurts to ask. And so I'm going to ask you this. And once again, I realize that you might not have been prepared to answer this particular question. But when you produced this program -- and you say it was a compact disk program -- was it a visual learning tool, or was it written material or both?
A. No, just written material.
Q. Okay. And you along with another author put this material together, apparently a Dr. Leach; is that right?
A. Dr. Gary Leach, yes.
Q. Okay. Would you be able to state one way or another if the material that you wrote at that time still constituted the standard of care that should be employed in the repair of vesico-virg- -- virginal. Oh, we are tired -- vaginal fistulas?
MS. O'BRIEN: Objection to the

Page 18

use of the term standard of care on a disk but -- if you can answer.
A. Yeah. There is -- there has not been a standard of care for this type of condition. The purpose of that course is primarily to educate urologists who are confronted with this condition on how to deal with it, how to evaluate it, and what are the principle of management.
Q. (BY MS. TAYLOR-KOLIS) Okay.
A. It's really in truth not a demand where we have guidelines or standard of care for assessment that everybody agrees upon.
Q. I guess I'm going to ask a vague question. Cheryl's going to say, "Good, I'll object."
Are there principles of management which should be adhered to?
A. I don't think so. The only way we could get to that would be through randomized trials; and this is such an infrequent condition that this probably will never happen, frankly. Most case report that you'll read in the literature will be, you know 10, 15 20 cases here and there over a number of years. So it's

Page 19

not -- it will take multiple centers when they put their heads together to help you with answering this question. As we speak today, we do not have an agreed-upon standard of care for everybody.
Q. When is the last time, Dr. Zimmern, that you yourself performed a repair?
A. I do probably -- this last year we did six. The year before I want to say seven. So I would say every couple of months. I just did a procedure a couple of weeks ago, and I just saw a patient yesterday that will need that repair done probably in June, July. So being a specialized center, I get referrals of these types of conditions.
Q. Okay. I'm going to ask you a question however inartfully. A vesico-vaginal repair is what kind of surgery, in your mind?
A. I'm not sure I completely understand your question, but I hope I answer the way you -- to answer really what you have in mind, it's basically repairing a hole or a communication that occurred between the bladder and the vagina. This communication does not exist naturally. It always happened after some form

Page 20

of event. And there are many etiologies. There are many reasons, many causes for why this can happen. Is this what you were asking?
Q. Well, that -- that was a good answer for the way that I asked the question. So let me ask a different question.
Is it fair to say that gynecologists and urologists both are able to do this repair?
A. Absolutely.
Q. Are there some instances relative to fis- -- we'll just -- whenever I say fistula repair, we'll assume for the sake of the question that we're talking about the kind of repair involved in this case but --
A. Fair enough.
Q. But -- right. A vesico-vaginal fistula, we'll just deal with those in and of themselves. Is there a situation where you believe that a gynecologist should not perform these repairs?
A. No, I don't think there is. This is a judgment call on the part of the physician. It will probably be based on experience. If the fistula is not something that that person

Page 21

repairs frequently, he or she may decide not to do it. If that person received proper training, I think, you know, if the patient has properly consented and understand the issues around the challenges of these repairs, I think it can be repaired by anybody who feels comfortable with this procedure.

Q. Okay. All right. I'm going to ask you some questions, and hopefully I won't keep you too terribly long. From your perspective as a urologist who has been involved in repairs of these kind of fistulas, what, Doctor, is the principle of delayed repair?

A. What is the principle of delayed repair? Yeah, that's a very good question. This started, if I may go historically back, in the 1970s by a physician named Roger Barnes from California. I had the privilege to train with his grandson who is also a urologist, Dr. Roger Headley. And back then women that had a fistula, the feeling was that you had to wait a number of months to allow the fistula to heal before you would approach it surgically. He bravely tried to operate on these women earlier realizing that it was a very miserable life to

Page 22

lead continuously, and was the first one to describe how you could do this operation through the vagina and achieve a successful result.

After that there was still -- people divided on when it should be done, and we've never completely all agreed that when's the optimal time. As a specialist, if someone comes tomorrow and just had a fistula and wants to be repaired, I will go ahead and do it. Many times I see people who have had prior attempts at repairs. It's been several months since the injury, and I will do it as soon as they can be scheduled. So I don't think we're very much bound by the timing anymore. We try to help these people because it is a very, you know, unpleasant condition to have.

Q. Okay. Would you agree that now the timing issue of a fistula repair is more dictated by the nature of the local tissue surrounding the fistula site than it is how far out you are from the development of the fistula?

A. No, I would not agree with that. It's

Page 23

one element in the decision process. If you do have someone who's -- an infection or someone who have had radiation or if you have any reason why you would want to wait because you think it's the proper thing to do, it's your judgment call. If you think that, you know, the -- you can see the hole. You can identify it, and it can be repaired, there's no reason to put someone through the miseries of continuous leakage for another day if you think you can fix it.

So the timing, the location, the quality of the tissues, all those are part of the elements that you as a physician have to put together to -- with your patient to make a decision. I have had a patient that have said to me, "We should wait"; and some others have said, "You know, I think the tissues are not going to be any better probably." You have chronic inflammation from the urine leaking there, and let's fix it. So, no, there's no rule of thumb for that.

Q. Okay. I'm going to get into the area where I have to question you on your opinions, and something just occurred to me. As you

Page 24

inventoried the material which you had, I did not hear you disclose whether or not -- maybe you don't it have. Have you received a copy of Dr. Hamontree's deposition?

A. Of Dr. who? Yes, I did. I have it here.

MS. O'BRIEN: He's pointing to the -- Donna, just to clar- -- he's pointing to the report which I think he thought you said. The deposition I just got this afternoon in my office. So we haven't even had it copied yet. He hasn't seen it.

THE WITNESS: Yeah. All I have is a one-page note dated April 28, 2005. That's all I have.

MS. TAYLOR-KOLIS: Okay. And that fairly answers my question. I just wanted to make sure that one way or the other whether he had or had not read Dr. Hamontree's deposition.

Q. (BY MS. TAYLOR-KOLIS) In your expert report that I received sometime later in March, you indicate -- and I'm just going to read it to you just for setting the table, so to speak. You said Dr. Makii met the standards for a trained board certified gynecologist. I'm

Page 25

assuming that you don't necessarily mean that you know the standard of care for a board certified gynecologist, but that he met the standards of care for this surgery. Is that a fair way to state that?

A. Well, I have a little bit of insight into what the board certified gynecologist should and should not do because I do work with them all the time. We do have a -- a fellowship which is run by the Board of Urology and the Board of Gynecology. So I know a little bit about what their curriculum should be and what it shouldn't and that -- knowing that, no. So that's why I wrote that.

Q. Okay. I just wanted to know why you wrote it that way.

You then go on to say: "Appropriate consenting was obtained in each instance." We'll be discussing that. Dr. Makii dealt with the complication in a timely fashion. Even though it is an unfortunate event after hysterectomy, Dr. Makii ultimately managed to render this patient dry again and continued to see her after her last successful attempt. Then you indicate: This

Page 26

is only a brief summary of my findings which I discussed in greater detail with you over the phone. "These opinions stem from the information I have reviewed thus far."

What I'm going to do is give you an opportunity to share with me what you told Ms. O'Brien were your more extensive opinions in this case.

A. Well, I went --

Q. I gather that you --

A. Yes, I went through --

MS. O'BRIEN: Let me -- let me just object in that our conversation was quite awhile ago; and it was long before he made out of country trips to France and everything, Donna. So in all fairness, I think from his notes he'll be able to give you a complete rendition of his opinions; but I also want to be sure that if you have any questions or any specifics, please do ask because he may not, you know, remember all the details. But anyway, go -- we'll let him go first, and then we'll see how we go from there.

MS. TAYLOR-KOLIS: That's fine.

A. I think what I was trying to communicate

Page 27

is that I couldn't see anything that was below the standard of care anywhere along in my review of these records. So we went step by step through the procedures, the operative notes, how the events unfolded all the way up to the resolution of the problem, the relationship between that physician and the patient, how she, you know, was acquainted with him, the fact that he just continued this care all along and ultimately fixed this problem which not always happens. I mean, many people will come to me after three, four, five repairs and still leak. So I think globally what I was trying to say to Mrs. O'Brien at the time is that I don't really understand very much the reason for this -- you know, for all this.

Q. (BY MS. TAYLOR-KOLIS) Okay. All right. We're going to do -- what I'm going to do -- actually have written this out in somewhat of an organized fashion. I want to go through with you some of the things that Dr. Makii said at his deposition. If you have his deposition handy, that will probably work for me.

A. Yes, I will pull that out here.

Page 28

Q. Okay. The first thing I want to discuss with you today -- we'll go to Page 25 of his deposition.

A. Yes.

Q. Okay. My question was to Dr. Makii, and then there's a question for you after it. "As you sit here today, Doctor, do you agree with me that there isn't any documentation contained within your chart that the presentation of this complication with the fistula, that you advised Lynn Keating and/or her husband, Kevin, that there were people available within the system" -- you see we're going -- we got to skip down right there -- "that had more expertise in fistula repairs?" And his answer was: "I can't recall if I did."

Do you feel, Doctor, that when a woman is confronted with a situation of developing a fistula following a hysterectomy that she should be given all options as to who might do the surgery and what kind of qualifications they have?

A. Well, I don't know how to answer that. It's basically a discussion between him and the patient. I never have the discussion with my

Page 29

patients, frankly, because they have had that discussion with other physicians before. And so they come to me to fix the problem. So I'm not very comfortable answering your question because I don't know what really transpired between them.

Q. Well, would you agree with me, Doctor -- and certainly you can refer to anything -- that the medical records that were provided by Dr. Makii -- and, of course, he is the author of both the inhospital records and the office chart -- do not reflect that Dr. Makii, A, discussed anything with Lynn other than immediately taking her for a surgical repair?

A. I don't think we can infer that from the records because it doesn't say that he didn't. Obviously he knew her. She knew him. She had assessed his qualifications, working in the same environment. She chose him for the repair. I'm sure he gave her some explanation. It looks like he answered your questions, you know, honestly. And I don't think -- you know, if they recall what they said to each other, that's one thing; but for us to say that they

Page 30

did not talk to each other and that this was not communicated, I don't think I can read that anywhere.

Q. All right. Well, let me rephrase and make it simpler for you. First of all, is part of the opinions that you hold in this case predicated on the fact that you believe what Dr. Makii testified to?

A. Well, here he testified that he can't recall if I did exactly. So I just have to take that.

Q. Well, have you taken into consideration the testimony of Lynn Keating wherein she indicates that options weren't discussed with her?

A. That's what she says. It doesn't seem to have the same opinion. I don't think I'm here to, you know, debate that, am I?

Q. Well, no. But that's my point. If there is a factual dispute between Dr. Makii and Lynn Keating on some issues, I need to know if you're resolving those facts in his favor to reach your conclusion that he was within the standards.

A. There is no standards about that that I

Page 31

know of. I can't give you a document that says what should be told a patient or not prior to procedure that I know of. I mean, maybe you have the document. I've never read a document like that. Obviously when you consent a patient, you have to explain the surgery you're going to do and the risk, and all I saw was a consent that described what she had and the repair was going to undertake. She signed it. And beyond that, I think it's -- I mean, it's just -- you know, I think we have to remain neutral here. We don't know.

Q. Well, I don't want to be difficult; but I guess my issue is this: If Dr. Makii's office notes do not reflect and/or his hospital notes do not reflect anything other than he explained to the patient that she would need a surgical repair, can we take that -- is that the standard you need to document what it is you discuss and tell a patient?

MS. O'BRIEN: I'll object in that that's a different question but --

A. Yeah. I think it's basically his practice. I don't know, you know, what he does. I think there was clearly a trust

Page 32

relationship between them. I'm sure -- you know, it shows all along. You just continue to care for her all the way through until she became dry. I'm sure he had no intention of, you know, delegating that care to someone else because she was trusting him to take care of her. So I don't know that he even spent too much time thinking that he had to write all this down, and I'm sure he gave her the information sufficient for her to proceed and sign a consent. It was not done forcefully in any way. She signed apparently and -- and she's a nurse. She obviously knows more than the average patient.

So I'm doubtful that they didn't discuss anything, frankly. I can't imagine that a nurse knowing a little bit about that physician would have accepted to an operation with no knowledge whatsoever of what he was trying to do to help her. So, again, this is inference. I don't think we know for sure that nothing happened or that nothing was said. That would surprise me a great deal.

Q. (BY MS. TAYLOR-KOLIS) Doctor, are you implying to me that there are no standards of

Page 33

care that require doctors to document their interactions with patients completely?
A. Not that I know of. I think the level of documentation varies tremendously. I'm just back from a trip in Europe. I can tell you you wouldn't find much in the chart in Europe. Here it varies a lot. In my many years of reviewing those entries some people are very detailed. Some say nothing.
Q. Doctor, do you participate in your hospital's JCHA evaluations?
A. We do. I don't do directly, but our university does.
Q. Do you suspect that JCHA has something to say about medical documentation?
A. Oh, they do; but I don't know what the standards are, you know, for Dr. Makii in the state he's in. I know what our standards are here at the University where we have an electronic record for everything we do. You probably know that more than I do. I really don't know that part.
Q. Moving on to my next line of questions. Page 38 in Dr. Makii's deposition. On Page 38 somewhere line -- about Lines 10 to 14 I asked

Page 34

him about the size. And this is questions that I'm asking out of his operative note. I said: "I think it was described as it says they were unable to see the entire bladder because as I stated earlier it was a small, I'd say, four- to five-millimeter hole." And he says: "Right."
I take it for purposes of my question you're going to accept that this was a four- to five-millimeter hole, right?
A. Well, if I remember correctly -- and I can recheck that -- he was able to put a catheter through it. So I think that would be a correct assessment.
Q. Okay. Doctor, can a four- to five-millimeter hole heal without surgical intervention?
A. The answer, maybe; but in reality I don't recall an instance where that would close by itself. The holes that have been in the literature stated as closing are usually smaller, like three millimeter or smaller. Again, here we're on a vague area because no one really has a caliper to measure that size exactly. So the way I judge that was the fact

Page 35

that he was able to put a small catheter through it, which makes sense knowing the diameter of the catheter and what he reported. And I think he has experience from when I read about him before about repairing fistulas. So it looks like it's a reasonable assessment and judgment on his part.
Q. Okay. I just want to establish that you're saying that a four- to five-millimeter hole wouldn't heal on its own?
A. Very unlikely.
Q. Okay. Our medical standard is more likely than not, meaning more than 51 percent. In your experience and based upon your review of the literature, a four- to five-millimeter hole wouldn't have healed on its own?
A. It would not, especially if you have a catheter, and the catheter does not provide dryness. So he tried to put the catheter, if I recall, properly and even increase the size of the catheter; and she continued to leak. So it's unlikely that it's going to -- you can send someone home leaking with a large catheter saying, you know, "Let's pray and hope it's going to close by itself." I don't think that

Page 36

makes much sense.
Q. Okay. All right. Moving on to my next question. On Page 46 of Dr. Makii's deposition, the question above where we're going to start because I wanted him to describe the surgical procedure he used in that first attempted repair. Have you read his description in his deposition of what he did, Lines 10 to 20?
A. No, I have not in detail read that because I read his operative note. So I did not pick up anything I was really concerned about. Okay. So I have read Lines 17 to 20. Okay.
Q. Okay. What -- what surgical procedure is he describing to you? And if you don't know what I mean by that, what technique is he describing?
A. He's describing basically a primary closure of a fistula. So he closes the bladder mucosa, the tissue in between, and then the vaginal mucosa. And he says --
Q. What tissue in between, I'm sorry?
A. Well, the tissue in between, you describe that as interstitial tissue. And usually it's,

Page 37

you know, the -- some bladder wall or some, you know, serosa material between the bladder and the vagina. So he tried to put, you know, additional layer of closure between the bladder and the vaginal closure.
Q. And based upon the description in his operative report and then his answer on that page, you feel he was using appropriate surgical techniques to ensure a repair of this fistula?
A. I'll go back to the operative records to verify that, but I would say yes to your question. Let me just reread the operative note to be totally accurate.
Q. Okay.
A. This is -- what's the date on this one? The first one was 9/25/03, correct?
Q. I --
MS. O'BRIEN: 9/30.
Q. (BY MS. TAYLOR-KOLIS) I believe she was historically --
A. 9/30, 9/30/03. Okay.
Q. Right. There you go.
A. To describe a four- to five-millimeter hole. So you put a pressuring suture like he

Page 38

describes, and then with another layer of pressuring over that. So you had two layers over the fistula, and the patient was dry. And so he felt that, you know, he had accomplished a watertight repair; and he was comfortable with the -- with the step. And he left the catheter to drain the bladder, and that was it. So I think that's fine.
Q. Okay. Doctor, is -- is it standard or standard of care -- and I know you are saying that you don't think there's standards, but we'll see -- at the time of a fistula repair, should the ureters be evaluated?
A. If you see the fistula where he described it and it's away from the ureters, that's all you can say. It doesn't say that it's close to the ureters anywhere.
Q. So you feel that it was not necessary for him to evaluate the ureters at the time of the first repair?
A. Well, I'm sure he looked at it. I mean, he's -- from what I've read from his histories, he's a board certified physician. He's trained as a gynecologist/oncologist. So he knows about ureters and pelvic cancers. So I have

Page 39

all reasons to believe that he checked that out. And if the person became dry after the hole is closed, why would you think that there is anything going on with another organ.
Q. Mrs. Keating stayed dry about six days, didn't she?
A. The next operation was on October 9. So I would say that's probably correct, yeah.
Q. Do you remember that she contacted Dr. Makii on October 6th, and she was leaking urine?
A. The exact date, no, I don't recall; but I know it happened, you know, in the following, you know, days after this repair.
Q. Okay. What do you make of Dr. Makii's testimony that the hole in the bladder is a new hole in the bladder?
A. Where would that be?
Q. You can look on Page 51, Lines 8 through 15.
A. Well, I think I -- I don't remember reading that in the deposition. I think I remember reading that in his operative note, which would be October 9. Let me reverify that.

Page 40

Q. Okay.
A. Where is this -- October 9th he looks for a hole. I think he was looking where the prior hole was and he couldn't find it and then he saw a jet of water coming from another location. So I think that's -- so it looks like, one, the place he had repaired had held; and another place maybe opened up that was not visible before. That could be an explanation.
Q. Do you have an opinion to a reasonable degree of medical probability as to why, first of all, this second area -- I don't know if you want to call it failed or was no longer intact?
A. I have seen this scenario before, and I think it has to do with the healing of what we call the cuff, the top of the vagina where the hysterectomy took place. All you can do when you repair a fistula is repair what you see, and you could -- you know, there obviously was nothing else leaking at the time. Otherwise he would have seen it. So I think he goes back and realizes that there is now another opening that was not obviously present last time he was there. So it -- you know, he probably assumed that what he had closed had reopened like you

Page 41

and I would have suspected, but apparently he meets another area where this occurred as well.
Q. In Dr. Makii's office notes -- and you can look at the notes. You'll look at the deposition. But at Page 52 I'm discussing with him what he wrote in his note. And he says -- I'm going to quote him. He says: "It says the concept for repairing this is pretty straightforward, but this is a relatively difficult time secondary to the problems she had earlier with steroids."
Do you -- do you agree that this is a difficult secondary problem because of her steroids?
A. That's an interest question. I don't know the answer, frankly. I looked at the dose of steroids she was on, and there is a -- the only thing I could find was a note from the cardiologist who cleared her for the surgery on 9/25 mentioning that she was taking steroids for her arthritic joint, that this crisis apparently had resolved and that the dose was being tapered. So you're looking now at a pretty low dose of Prednisone, five milligram. We operate on people who are -- you know, on

Page 42

immunosuppressant, a much higher dose, without being too worried about it.
So maybe for him it meant he was more concerned or maybe for him that explained why she didn't heal as well as someone else would have healed. I think it's very hard to tell that for -- for -- is this the only reason, I don't know that. She's not on a high dose of steroids. You know, I think she's really at a -- she probably just had a boost of steroids just because of the arthritis issue. And it's, you know, about to be out of her system. So I didn't make much of that, to be honest with you.
Q. All right. So you wouldn't have been concerned about the steroids in this instance; is that correct?
A. That's right, I would not have been.
Q. All right. And do you believe that the dosage of steroids that she was on as calculated by yourself in looking carefully through the notes would have affected her ability to heal?
A. Well, that's what's difficult to tell because I don't think we know that how long the

Page 43

steroid effect could prevent this area from healing. That's why I can't say that this is not contributing to this problem. But to say that's the only reason why it happened, most of the time the fistula I've dealt with, people were doing their procedure and never even have a clue that anything was going on. And it happens. So it happens with people that do not take steroids. So to say that this is why, may be a little bit farfetched to be really fair. To say did not contribute, no, I don't think you can say that because, yes, steroids do affect your healing properties. So that's a fair comment. I would not have -- I mean, if a patient come like that to me tomorrow, I would go ahead with the repair. You know, I don't think that would have stopped me from repairing her at the time.
Q. Okay. On that same page, Page 52, I was having a conversation with Dr. Makii back in November. What -- we began to talk about how long it had been since that initial fistula repair, and it's Line 20 through 25. He says, "Yeah, it's several weeks from the initial surgery that we did her hysterectomy, and then

Page 44

it's a week out of -- roughly a week out of the repair of the fistula that we had done. And so at this point in time, you know, the tissues are going to be more edematous and more friable."
Would you agree with him that that's the way the tissues would have been at that time?
A. Probably -- probably true, but this is a young person. She's otherwise healthy. She's 50 years old. You know, tissues heal pretty quickly. I think it's -- you know, he was there. I wasn't. So, you know, it looks like it's his judgment call that maybe, you know, this could contribute to the whole process. I'm not sure I know what to -- I mean, it's not surprising that what the -- you know, all tissues after surgery have some edema and are friable. So I think it's correct, but I can't quantitate that for you or say, you know, this has anything to do with what happened afterwards.
Q. Okay. Going further in Dr. Makii's deposition testimony on Page 54 starting at Line 13 I ask him, and once again more relative

Page 45

to the second situation: "Why did you suspect -- well, what was the cause of the leaking in your opinion at that time?" And he say: "Well, first I didn't see that it was in the area that we had repaired, and it was along the mid portion of the vaginal cuff. So I was thinking that we had an erosion of the sutures through the posterior bladder wall."

Doctor, do you think that that's what happened, there was an erosion in the sutures through the bladder wall?

A. I mean, that makes some sense given what he described in his report.

Q. Now, how does that happen that the sutures erode through the bladder wall? What would be the cause of that?

A. Well, some people will say that, you know, when you tie them if they're tied too tight, you can cut the blood circulation. Some people have suggested that maybe your body's reactive to the sutures. So you increase an area of inflammation. I think all of these are different, very conjectural thoughts, you know. I think he's trying to understand what may have happened, but I don't know if we'll ever know.

Page 46

It just happened. Most of the time we don't know. There's a hole, and we have to fix it. That's the bottom line.

Q. Okay. This particular second repair, Doctor, I don't know if you remember it; but it will be easy to remember because the doctor testified to it. This particular procedure took three hours. When I asked him about it, if you look on Page 56, his answer to me when I asked him why it took so long to do this procedure, he said: "We had a lot of bleeding and as I previously said previously, the tissue was rather necrotic. So we had to cut it back until we got good, good tissue."

Do you see that?

A. I see that, yes.

Q. That's his testimony that at that time when they went in to do this particular repair that the tissue was very necrotic.

A. I see that.

Q. Okay. Again, Doctor, at the time of this particular procedure preoperatively, interoperatively should there have been a complete evaluation of the ureters?

A. I don't think so. Again, the way you

Page 47

describe is he does a cystoscopy; and he finds, you know, a new hole. So he sees the hole, and the hole goes clearly from the bladder to the vagina. So I'm not sure that there's any reason to question what's going on with the ureters.

Q. Okay. What would lead you to believe something was going on with the ureters? What sort of symptoms would you see?

A. Well, if you close the hole between the bladder and the vagina and the person still leaks, obviously there's a hole somewhere else. If the person has fever, flank pain because they -- the tube has been kinked or is not draining properly, those are the types of things that usually, you know, raise suspicion. Or if you look at the time of your scope and you don't see any jet of urine coming out, you may, you know, wonder. But that's -- usually you're worried when the hole is close to the ureters, which is not a frequent issue when the injury occurs at the time of the hysterectomy just because the cuff is usually fairly far from the ureters and what we call the trigone, which is the area between the two ureters. So

Page 48

usually those fistulas of the cuff are far away from the ureters. So it's very unlikely that the ureters had anything to do with this, and it's probably why he didn't even care for it.

Q. She ultimately had a problem with her ureters. Would you agree with that -- ureter?

A. There was some swelling around the ureteric orifice which prevented the kidney from draining well on the right side. But we can't say there was really a problem. They were able to pass a stent easily, and ultimately this area healed. So I think if there was a problem, then things would not have healed. And it's common when you open the bladder that you get to have some tissue swelling, and the tissue swelling can involve, you know, the ureter. They are in close proximity. So, no, that doesn't surprise me much. It's a common problem.

Q. Okay. Doctor, do you have an opinion to a reasonable degree of medical probability as to whether or not the second repair which occurred on October 9th should have been a flap procedure?

A. Can you explain what you mean by a "flap

Page 49

procedure"?
Q. The procedure that was ultimately performed the third time.
MS. O'BRIEN: I'm not sure I understand that question. I think I can -- are you asking him whether or not he thinks the procedure that was ultimately done on 11/7 should have been on 10/9 and because it wasn't --
MS. TAYLOR-KOLIS: Correct.
MS. O'BRIEN: -- was it beneath the standard of care? That's what she's asking.
MS. TAYLOR-KOLIS: That's absolutely correct.
A. So the question is should he have opted for abdominal surgery at the time as opposed to going back vaginally?
Q. (BY MS. TAYLOR-KOLIS) Correct.
A. Again, here you have to go with his judgment and expertise and experience. It's preferable to continue to work vaginally, especially in this particular patient, if I recall well, she has had two prior scars from C-section and appendectomy. They had

Page 50

difficulty with her rectus muscle on the right side. So I would be very tempted not to go in the abdomen again. So I have no problem with his judgment call to go back through the vagina. And here again, from reading his notes, he seemed to have achieved a satisfactory repair. Everything is dried, and he was able to put several layers on top. So I think he exercised really good judgment. I mean, this is not someone I would want to reoperate through the abdomen.
Q. Okay. If you look at the office notes, on October 24th Dr. Makii pulled out the Foley. But at that time he did not get a cysto. Do you think that that is below the standard of care?
A. I'm lost here. Is it still in the deposition? I don't know where we are.
MS. O'BRIEN: No. I think you're just asking him straight out of the office record, aren't you Donna?
MS. TAYLOR-KOLIS: Yeah.
Q. (BY MS. TAYLOR-KOLIS) Yeah, it's in his deposition, but to make it easier on Page 62, lines 15 through 20, I discussed with

Page 51

him -- right. I said -- the question I asked him was -- the line of questions. This is when he pulls out her cysto on the 27th -- her cysto. It's too late in the evening to be doing this deposition. Her Foley. "Is it because usually before I pull, before I pull a catheter, I usually get -- I want to see because I usually get a cystogram. No, I didn't get one." Customarily I said: "Why do you get one?"
He said: "To make sure that she does not have any further leakage and that the repair is intact."
So my question to you is: Should she have had a cysto on the 27th?
A. A cysto meaning a cystogram?
Q. Yes.
A. I don't think we have an agreement on that. Some people do. Some people don't. There are arguments against a cystogram, and those are the risk of, you know, bringing infection in the bladder or distending the bladder too much and, therefore, maybe stretching the repair and reopening the fistula. So, you know, I think if the person

Page 52

is dry, the cystogram does not add anything. If the person leaks, you really want to know where the leakage comes from maybe.
But, you know, I think again here it looks to me like what transpires through his report all along that it is a fairly good level of comfort with what he did achieving dryness. And he has said in his deposition that he has been trained to do fistula repairs. He has done them in his training. I think he feels competent to take care of her. And he documents each time that he has accomplished the goal of making her dry.
So I don't think he's doubting his results, frankly. So why would you ask for an extra test with the reddition involvement, the risk of infection, stretching the bladder for what, you know. So I have no problem with him not getting one. I probably would not have gotten one either myself at that stage.
Q. Doctor, do you recall that by November 3rd Mrs. Keating was, once again, leaking; and she describes it as spraying uncontrollably, correct?
A. Yeah. I don't remember how she describes

Page 53

it, but she apparently -- something happened at some point. She went to San Diego or she went to see her parents or something happened and -- this is a bit vague in my recollection of what happened during that one month or so. But the bottom line is what she said. She started to leak again.

Q. Right. Well, there wasn't a month -- I mean, from the 27th when he starts on November 3rd, that's not very many days, is it?

A. Well, the second repair was October 9, correct; and his next repair was 11/7. So it's almost a month. So I just don't know the exact timing of when it recurred. I don't know exactly when she left to San Diego to see her parents either. But I suspect she went there and was doing fine. Otherwise, she would not have probably decided to go that far away from him. So I have to suspect she was dry for a while, correct?

Q. Could you know -- in the interim between the time of that repair and then the time of the visit where he pulled the Foley, could you say she was dry during then?

A. I don't know if I can say that. I don't

Page 54

know if I cannot say that. I don't remember specifically -- I mean, I would assume that if you remove the Foley is because she's dry. Otherwise, why would you remove the Foley. But then after that how long it took for the leak to reoccur -- no, I would tell my patients not to travel as far away as she did if she had that type of repair, frankly. So I was surprised to see her go, you know, away just after, you know, this repair. Again, they may have talked about that together; and he may have told her that it was fine. I don't know that.

Q. But you wouldn't have told a patient to take a trip that extensive, would you?

A. No, I wouldn't.

Q. Okay. And there's no documentation that Dr. Makii put those kind of restrictions on her, is there?

A. Well, as you pointed out before, there may be many things that he has said and not documented because, you know, I don't know if I even document that in my -- I don't tell my patient, "Don't go to San Diego," after my repair; but I will tell them, you know, "I will

Page 55

like you to have, you know, a more quiet lifestyle. Make sure there's no pulling or tugging on your body, that you're not going to travel too far or too much." And it's kind of a common sense, you know.

I don't know if he knew she was going to travel. Again, they work in the same hospital. He described her initially in his report as being a friend of mine. So did she call him and say, "You know, by the way, I'm going to San Diego. Is this fine with you?" I don't know that, you know.

Q. Dr. Makii described Lynn Keating as being a friend of his at his deposition, correct?

A. Yes. That's what I read. He said, "She's a friend of mine."

Q. Right. But he didn't say that in his medical notes or his hospital chart, correct?

A. That, I don't recall. I remember reading it in his deposition. I was interested to know what type of relationship they had.

Q. Okay.

A. Maybe it's somewhere else. I don't know if it's somewhere else.

Q. If you can find it someplace else, I

Page 56

cannot. It's what he testified to at his deposition.

A. Okay.

Q. Okay. Direct your attention to Page 66 of Dr. Makii's deposition.

A. Yes.

Q. He and I had been having a discussion on the previous page about why the sutures were disrupted, et cetera, after the 27th but up to the time of the 3rd. And what I want you to focus on -- and I'm going to read this to you, and we're going to talk about what he says in his deposition.

"I think as I explain, or maybe I didn't, but in these repairs usually if you do these repairs, usually we wait for a while for the underlying inflammation to die down and then go back to when there's more of an established scar tissue and less inflammatory response. And then -- then we do the repairs. These were all discussed with Lynn and she did not want to wait three months and that's part of the reason why."

Do you get the clear import from that note?

Page 57

A. And then he adds: "And being a friend of mine, I felt I could try to help her as much as we could."

Correct, that's the end of the -- of the paragraph.

Q. Yes, and thank you for reading that; but my question doesn't have to do with his assertion that she's his friend. Do you read that to mean that Dr. Makii believes, contrary to what you said, that you really should wait for a period of time before you do this repair?

MS. O'BRIEN: Objection in that you said that's contrary to what Dr. Zimmern said. I didn't hear any testimony to that effect, Donna; but if you want to ask your question.

Q. (BY MS. TAYLOR-KOLIS) Dr. Zimmern, I believe that you testified way early in the deposition, because that's where my questions were, about timing no -- I discussed with you the principle of delayed repair, and you said that was no longer a principle that people can and do --

A. Some people hold this as an absolute principle. Some others are more lenient about

Page 58

it. I have learned, you know, over the last 25 years that you can be more lenient. And so you can go ahead early, and you can go ahead late. Usually people go ahead as soon as they can to fix it in their own judgment. So, yeah, I agree with Ms. O'Brien. I don't think, you know, there is again a party line of when you should absolutely go in. For a long time the prevalent idea that you had to wait; but as I explained, this has evolved towards people would go in early or whenever the patients present, so...

Q. If you go to Page 67, lines about 21 through 25, I believe, so that it's clear -- and I want to make sure that you understand it -- do you understand Dr. Makii's testimony to be that under the circumstances of Lynn Keating that he would have preferred not to do a surgery because he believes that her best chance for fixing this problem would have been to rest that area?

A. Yeah. I think that's what he does indicate.

Q. Okay. And he claims that it is Lynn that did not want to wait, and so he went ahead and

Page 59

did the surgery; is that right?

A. Well, that was my impression as well.

Q. And, once again -- and I'm not going to be beat a dead horse -- can you agree with me that those kinds of pieces of advice, any of those conversations are not contained anywhere within the four corners of the medical records?

A. I would agree with you, I did not see that in writing anywhere either.

Q. Okay. All right. What I'd like to do now is you may -- obviously you do know that Ms. O'Brien had the opportunity to already take the deposition of Dr. Hamontree. That's how we do things. My guy goes first, and then we take you. So what I want to do is I'm going to read to you out of Dr. Hamontree's deposition some of his opinions, and I'd like for you to comment on them. Okay?

A. Okay.

MS. O'BRIEN: Donna, let me just put an objection on the record in that he has not seen it. He hasn't had the chance to read it in context, and it's putting him at a tremendous disadvantage. But it's your deposition. So go ahead.

Page 60

MS. TAYLOR-KOLIS: Right. And I'm not trying to put him at a disadvantage. I think the context will be clear because they were straightforward questions by yourself as to what the deviations were. So I don't think there's a whole lot of possibility to be confused but -- because I just want to go through them just to see how Dr. Zimmern might reason through what Dr. Hamontree thinks.

Q. (BY MS. TAYLOR-KOLIS) Essentially we're going to Page 23, and I'm sorry Cheryl does not have one. But if I'm wrong, the verbatim will work out.

Initially they're looking at the situation that occurred on 9/30, and the first thing that Dr. Hamontree has concern with is as follows, Page 23 Lines 14 through 25: "My criticism -- or let me just summarize the problems. We want to go through the op report because you lead me there. But the problems that I see is this: There were no upper tract evaluations performed such as an IVP or a retrograde ureterogram."

Do you disagree with Dr. Hamontree that that's a problem?

Page 61

A. I don't view that as a problem for this particular situation. I think if the fistula was close to the ureters, if the patient had not been made dry after the repair, yes. But the assessment of the upper tracts, again, is something that some people do; some people don't. In my particular practice, because I deal with patients who have had several repairs before, I tend to be -- agree more with Dr. Hamontree, and maybe that's where he's coming from. We really want to check everything out before we go through the 5th or 6th or 7th repair. But, again, here in the context, I would not support this as being, you know, a firm, you know, below the standard of care type of thing, not at all.

Q. Okay. Skipping down the same page -- I'm just going to go to the next page, Page 23 of Line 23: "He essentially did a purse string of the bladder and a purse string of the vaginal epithelium, one right on top of each other. There was no -- so there was overlapping suture line, no intervening healthy tissue."

Do you agree with his assessment that that's what occurred at this surgery, that

Page 62

first of all what we've got is a purse string of the bladder and a purse string of the vaginal epithelium, one on top of each other?

A. You're referring to the 9/30/03 procedure?

Q. Correct.

A. Yeah, the problem with the purse string -- and we all know what a purse string looks like. I don't know if you can say that it overlaps because when we do several purse strings, most of them don't overlap. You're going to have one purse string right around this four-, five-millimeter hole; and then you're going to have, from what you describe, a wider purse string to kind of imbricate it over. So I can't physically imagine how they can overlap. They're going to be in different planes, one reinforcing the other, but not on top of each other, obviously. I mean, you can't put a second purse string where the first one was. So I'm not sure I understand this issue that -- or what he's trying to say here.

Maybe it's my understanding of the words purse string. When we do a purse string, we basically throw a suture gradually,

Page 63

you know, like when you repair a hole in your shirt or anything else. So you do the first area, it's closed. It's dry. And then you got to have another purse string, obviously taking tissue further out away from where the hole was initially. So I don't see how that can overlap at all. Maybe it's my understanding of what he describes, but I don't see it as a problem at all.

Q. Okay. What do you make of his contention that there was no intervening healthy tissue?

A. Well, there cannot be any, otherwise you would have a hole, correct. I mean, you have -- a fistula goes directly from the bladder to the vagina. So you don't have anything in between. What we usually do, we try to bring tissues from lateral to the hole to try to have the layer or, you know, some form of interposition. And usually the adjacent bladder tissue is healthy enough that you can do that. And that's, again, what I think he's trying to do with this second purse string.

Q. Okay. Once again, we probably already covered this; but I'm just going to

Page 64

do -- Ms. O'Brien did a nice job of logically following through to find out what his criticisms were. And on Page 25, line of questioning 15 through 25, Cheryl is saying -- and I asked you one way, and you answered another. But I think we're in agreement as to what you're saying. This leads me to my next question. If, in fact, your conclusion is accurate that what he achieved was overlapping or adjacent suture lines, do you feel that fell below the standard of care and was negligent? His answer, Doctor, is: "I think it is, particularly doing a repair immediately after surgery rather than waiting or trying conservative treatment."

"Will you know whether or not he authored the treatment or if that was discussed with the patient?"

"I don't know, but I think if you were going to undertake an immediate surgical repair in tissue that has just been operated on, then you really, really have to adhere to the guiding principles of a fistula repair; or you are going to have to have a high chance of failure of a recurrent fistula."

Page 65

Having read his question and answer -- I'm not asking if you agree with his answer -- Doctor, do you believe that there are principles of fistula repair in terms of surgical technique?

A. There are principles that have been, you know, published. If everybody who does fistula repair have their own principles, it's like, you know, the cook in the kitchen is doing a recipe his way and someone else does a different way. Do we all agree on the principles? We don't. I train in two countries, and I can tell you the way I repair fistula now has nothing to do with the way I was taught to repair fistula. And as I said earlier, unfortunately we don't see that problem frequently enough that we will probably ever sort that out.

So I'm sure that Dr. Hamontree refers to principles he has in mind, which probably ten other people in the field would probably disagree with to some degree. Here he's arguing that he should not have done this repair, you know, at the time when it is clear that he has tried to control the leakage with

Page 66

increasing size catheters. You know, he knows that if -- it's going to be a hard thing to live with to have this continuous leakage; and he's trying to help her by fixing the problem early on, which in my experience is a way to go if you recognize there's a problem, why leave someone miserable when you have a small hole that is potentially fixable.

Q. Okay. So you got sort of away from my question, but that's all right. Doctor, you've indicated to me on the record that you are training residents and fellows. And I assume that's residents and fellows in urology, correct?

A. That is correct.

Q. All right. Are you the person responsible, either in a didactic setting or clinical setting, to teach your urology -- I'm going to call them students, but they're far more than students -- how to do a vesico-vaginal fistula repair?

A. Correct. That's my own recipe, yeah.

Q. Could you tell me what Philippe Zimmern's recipe is for this kind of fistula repair?

A. Do you have another three or four hours?

Page 67

I can -- I mean, I can --

Q. I --

A. It's a great question, but it will depend on where it is, how large. I mean, there's so many factors. There's not just one way, unfortunately. So, you know, you're trying to -- you can't reduce it to fixed like, you know, dogma, like if you have pneumonia and you need some antibiotics to fix the pneumonia, this doesn't happen for this type of problems. I have never seen two equal fistulas. I have never seen two people with the same problem, the same tissues, the same set of circumstances. So I agree that the principles are good in general, but we're never shown that if you depart from some of those principles it means that the repair will fail.

Here you have someone with training, who feels comfortable dealing with it, tries a conservative approach that clearly doesn't work, wants to help the patient achieve dryness during the procedure. You know, that's her life. If all operations we did were successes, that would be wonderful. And these things happen where people fail. I mean, I see

Page 68

that all the time. So I wish we had principles. And when I discuss that with our residents and fellows, I explain that the way I do it is the way I've evolved into doing it; but I have failures like everybody else. It's hard to admit that we can fail, but we do fail.

Q. Doctor, do you believe that there is such a thing as medical malpractice?

A. Yes, I think I do because we have -- we have to take tests every year about that. So we do have, and we have a law in Texas about that.

Q. What kind of law is that?

A. You're asking me too much. I'm not a lawyer; but, you know, we have malpractice law where our university asks us to take courses about that, you know. So I don't know if there is a name or a year specific to it. That's not my field of knowledge, but we know we have malpractice laws in Texas.

Q. Okay. I guess I was confused about what you just testified to. I was interpreting it to mean that the University required that you, Dr. Zimmern, take a course to understand the laws of medical malpractice in Texas.

Page 69

A. Yes.
Q. Did I misinterpret?
A. No, no. This is correct. We have to answer a certain number of questions every year or every two years. I can't remember how often that is. It's not a course. I think it's a multiple choice question that we have.
Q. And out of curiosity, did you pass or fail that test?
A. No. I've always passed. All our faculty pass.
Q. I thought that was a great question, personally.
MS. O'BRIEN: A little out on a limb, it's fairly irrelevant, but go ahead.
MS. TAYLOR-KOLIS: Yeah. You know, I guess what I'm going to --
MS. O'BRIEN: It's the hour.
MS. TAYLOR-KOLIS: It probably is partially that.
Q. (BY MS. TAYLOR-KOLIS) And this won't get me any great trial testimony, but are you one of the physicians who's been out advocating medical malpractice tort reform over the last year, eight years?

Page 70

MS. O'BRIEN: Objection; irrelevant.
Have you even had the time to do that?
THE WITNESS: I wish I had the time to do that.
Q. (BY MS. TAYLOR-KOLIS) Okay. So you're in favor of medical malpractice tort reform?
MS. O'BRIEN: Objection. Move to strike. But for your own personal edification, you're certainly welcome to his opinion.
A. Yes.
Q. (BY MS. TAYLOR-KOLIS) Okay. Let me see. If I take what you have said to me, even though your -- and how many residents and fellows do you have in your program, Doctor?
A. Great question. We have 16 four-year, over four years. And I have been involved with a fellowship program now for seven years with Dr. Leach and ten years here at the University. So 17 years.
Q. Okay. Having said that, I gather, then, that you have taught the principles of vesico-vaginal fistula repair for some time and

Page 71

to a large number of people?
A. No, that's not correct. I don't teach principles.
Q. Okay.
A. I explain to people how I try to repair fistula and the type of issues I've encountered in my practice. But I have yet to agree with principle that Dr. Leach or someone else in the field would agree with me. We don't have those, I'm sorry to say. There are concept, there are ideas, but principle is a very strong word. It means that if you don't do that you're doing something wrong, and we don't know that.
Q. Okay. Can I infer from that, then, that -- and I could be inferring the complete wrong thing, that anytime that there is a failed fistula repair it possibly could not be from medical negligence; it's just from a judgment call?
A. Neither one. It just -- could be just that the repair did not hold, period. We don't even understand why this fistula formed to start with most of the time. So healing is not something that we control. I wish we could.

Page 72

Q. Okay. Doctor --
A. I don't think you realize the complexity of fistula repair. This is not an easy topic because we don't have much knowledge. We don't have much scientific knowledge about it. There are many different ways of doing things depending on your background and your training. All I see here is someone with apparently credentials to do this repair who failed initially but ultimately made it through in a short time all together. Because I see some of these problems evolving sometimes over two or three years. And I don't see anything below the standard of care here.
Q. Doctor, when was the first -- since you seem to be obviously a very interested academic, can you tell me from your knowledge of the medical literature when the first fistula repair was described?
A. It was -- it was back, you know, in the slave times where people were using, in fact, metal to close that. And the first patients that were treated were, in fact, black slaves. You're going back to the end of the last century. And there are different names, but I

Page 73

don't believe that matters that much.
Q. No. Do you aid and assist in preparing the examinations, the written examinations for doctors who successfully complete their residency program and then wish to become board certified in urology?
A. I do not.
Q. Are you aware as to whether or not a section of that examination includes within it the concepts of fistula repair?
A. I like your term "concepts." That's different than principles to me. So there may be. I don't know that particular part.
Q. Okay. All right. I've spent enough time with you this evening. It's my understanding that we'll be videotaping your deposition on the 24th of April.
MS. TAYLOR-KOLIS: Is that correct, Cheryl?
MS. O'BRIEN: That is.
Q. (BY MS. TAYLOR-KOLIS) You are unavailable for trial, Doctor; is that correct?
A. Yes. It's very hard for me to leave. As I described earlier in my practice here which I am booked in surgery a couple of months in

Page 74

advance, and this is very hard for me to leave. That's why we chose the evening on my own time to do that.
MS. TAYLOR-KOLIS: Okay. Doctor, I thank you for your time. Prepare your bill. Forward it to Ms. O'Brien. I'll make certain that you get paid.
Cheryl, are you flying out tonight or tomorrow?
MS. O'BRIEN: Tomorrow.
MS. O'BRIEN: In terms of waiver can we have an agreement that we've waive the seven days? I mean, we'll get you the transcript, and then he can follow up with any corrections and so forth before trial but --
MS. TAYLOR-KOLIS: It if -- I'll give you waiver on the seven days, but I've got to have whatever it is by Friday before trial.
MS. O'BRIEN: Yes, absolutely. You're talking about corrections. Yeah, I'm sure you'll have the transcript before then; but, yeah, any corrections we'll get them to you before trial.
MS. TAYLOR-KOLIS: Okay. Perfect.

Page 75

MS. O'BRIEN: Thank you.
(END OF PROCEEDINGS 8:30 P.M.)

Page 76

CHANGES AND SIGNATURE

WITNESS NAME:		DATE OF DEPOSITION:
PHILIPPE ZIMMERN, M.D.		April 11, 2006
PAGE/LINE	CHANGE	REASON

I, PHILIPPE ZIMMERN, M.D., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

PHILIPPE ZIMMERN, M.D.
Job #57036

THE STATE OF _____)
THE COUNTY OF _____)

Before me, _____, on this day personally appeared PHILIPPE ZIMMERN, M.D., known to me (or proved to me under oath or through _____) (description of identity card or other document)) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office, this _____ day of _____, _____.

NOTARY PUBLIC IN AND FOR
THE STATE OF _____
COMMISSION EXPIRES: _____

STATE OF TEXAS)
COUNTY OF DALLAS)

REPORTER'S CERTIFICATE

I, DAWN M. GREEN, Certified Shorthand Reporter in and for the State of Texas, hereby certify that this transcript is a true record of the testimony given.

I further certify that I am neither attorney nor counsel for, related to, nor employed by any of the parties to the action in which this testimony was taken. Further, I am not a relative or employee of any attorney of record in this cause, nor do I have a financial interest in the action.

Subscribed and sworn to on this the 17th day of April, 2006.

Dawn M. Green, CSR
Certified Shorthand Reporter
In and for the State of Texas
Certification No. 5178
Expiration Date: 12/31/2007